Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Bell, a prisoner at HMP Forest Bank, on 6 July 2025

A report by the Prisons and Probation Ombudsman

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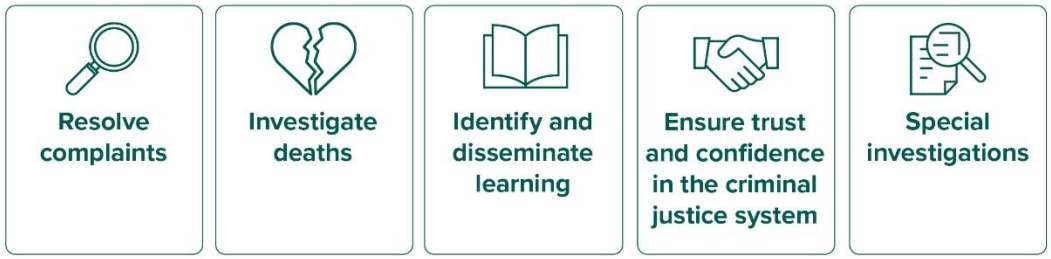
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr James Bell was found hanged in his cell at HMP Forest Bank on 6 July 2025. He was 34 years old. I offer my condolences to Mr Bell's family and friends.

Just over a week before he died, Mr Bell told staff that he did not want to leave his cell because he felt under threat. The investigation found that staff took no action to explore why Mr Bell felt under threat, missed an opportunity to manage him under Forest Bank's isolating prisoner policy and therefore did not put supportive measures in place. As a result, staff were poorly placed to identify whether his risk of suicide and self-harm had increased.

I am concerned that the operation of two separate policies dealing with prisoners who choose not to engage with the standard regime (the Do Not Unlock policy and the isolating prisoner policy) does not best support the needs of prisoners at Forest Bank.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **April 2026**

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Summary

Events

1. On 22 May 2025, Mr James Bell was sentenced to 14 months in prison for actual bodily harm (ABH). He was sent to HMP Forest Bank. It was not his first time in prison.

2. On 28 June, Mr Bell handed a note to the night operational support officer (OSO) stating that he wanted to be put on the Do Not Unlock (DNU) list (prisoners who have asked for their cells not to be unlocked because they fear other prisoners) and be moved to a different wing. The OSO added Mr Bell's name to the DNU list and made a note in the wing observation book. There is no record that anyone spoke to Mr Bell to ask him why he did not want to be unlocked or why he wanted to move to a different wing. Staff did not apparently consider that Mr Bell might also fit the criteria for an isolating prisoner, which would have triggered a different approach.

3. On 30 June, staff moved Mr Bell to A Wing. There was no handover so staff on A Wing did not know that Mr Bell was on the DNU list.

4. On 2 July, the national intelligence unit phoned Forest Bank and said that Mr Bell had reported that he was going to be assaulted that afternoon and should be kept locked in his cell for his own safety. Staff kept Mr Bell's cell locked and took his meals to him. CCTV shows that Mr Bell did not leave his cell again before his death.

5. At around 8.20am on 6 July, officers started unlocking prisoners for activities. When they reached Mr Bell's cell, they were unable to open the door because it felt heavy, as though something was leaning against it. They were unable to look through the observation panel as it had been covered. They forced the door open and found Mr Bell hanging from the door frame with his wrists and ankles tied together. The officers called a medical emergency code and the control room called an ambulance. There were obvious signs that Mr Bell had been dead for some time, so staff did not start CPR. Ambulance paramedics arrived at 8.39am and pronounced life extinct at 8.42am.

Findings

6. Although Mr Bell had asked to be placed on the DNU list for his own safety, staff failed to establish the reasons for this and failed to assess whether he was isolating. As a result, staff did not follow the prison's local isolating policy and missed an opportunity to put supportive measures in place for Mr Bell. The failure to explore the reasons for his change in behaviour meant that staff were not well placed to identify any increase in his risk of suicide and self-harm.

Recommendations

- The Director should:

- Review the appropriateness of maintaining both a Do Not Unlock process and an isolating prisoner policy to manage prisoners who do not engage with the standard regime.

- Ensure that staff are clear of their responsibilities under either approach including establishing the prisoner's reasons for not engaging with a standard regime, and recording and communicating the prisoner's status, particularly if the prisoner is moved.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact her. No-one responded.

8. The investigator visited Forest Bank on 8 July. She obtained copies of relevant extracts from Mr Bell's prison and medical records.

9. NHS England commissioned an independent clinical reviewer to review Mr Bell's clinical care at the prison. The investigator conducted interviews with four members of staff over video call.

10. We informed HM Coroner for Greater Manchester West of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. The Ombudsman's office contacted Mr Bell's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She raised no issues but asked for a copy of our report.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS. They found no factual inaccuracies. They provided an action plan which is annexed to this report.

13. We sent a copy of our initial report to Mr Bell's next of kin. They did not notify us of any factual inaccuracies.

Background Information

HMP Forest Bank

14. HMP Forest Bank, managed and operated by Sodexo Limited, holds adult men, both on remand and sentenced, as well as young adult prisoners aged 18 to 21. The prison serves the courts of Greater Manchester.

15. Spectrum Community Health CIC provides primary healthcare and clinical substance misuse services 24 hours a day, seven days a week, and pharmacy services Monday to Friday from 9.00am to 5.00pm. Change Grow Live (CGL) provides non-clinical substance misuse services, Monday to Friday from 9.00am to 5.00pm. Greater Manchester Mental Health NHS Foundation Trust provides mental health services, Monday to Friday from 9.00am to 5.00pm.

HM Inspectorate of Prisons

16. The most recent inspection of Forest Bank was in December 2024. Inspectors reported that safety outcomes were “not sufficiently good”. Violence levels at the prison remained high, particularly assaults between prisoners. Around 30% of survey respondents said they felt unsafe. Inspectors found that low-level bullying was often ignored or not properly investigated, contributing to a culture where poor behaviour went unchallenged.

17. Inspectors found that overall rates of violence, including serious assaults, had increased since the last inspection and were now higher than most similar prisons. Inspectors also identified several complaints and concerns raised by prisoners about low-level bullying that had not been adequately investigated or reported. Staff on residential units did not always challenge poor behaviour and rule breaking, and this created an environment where bullying could prevail. Leaders were rarely visible on residential areas at key points of the day. They were not proactively setting standards or supporting some inexperienced staff who struggled to enforce rules and maintain boundaries.

18. Inspectors found that leaders had identified safety as a key priority, and there was cohesive work between staff in safety, security, and residential functions demonstrating an effort to address the high levels of violence. In addition, a daily movement of prisoners meeting managed the location of prisoners to minimise risk, including that posed by prisoners affiliated to urban street gangs in the community.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to 31 October 2024, the IMB noted a significant increase in prisoner turnover and a rise in the prison’s operational capacity. Staff were managing a 13% rise in violent incidents, alongside a growing number of prisoners with moderate-to-severe mental health conditions and neurodiverse needs.

20. Although the prison had been actively recruiting new officers throughout the year, it continued to face challenges in training and retaining them effectively. The IMB also raised concerns about the limited delivery of key worker sessions, with many prisoners unaware of who their key worker was.

Previous deaths at HMP Forest Bank

21. Mr Bell was the 18th prisoner to die at Forest Bank since July 2022. Of the previous deaths, four were self-inflicted, ten were from natural causes, two were drug related and in one, the cause of death was unascertained. Up to the end of November 2025, there have been two further deaths, one self-inflicted, and one from natural causes. There are no similarities between the findings from our investigation into Mr Bell's death and the findings from our investigations into the previous deaths.

Isolated individuals

22. Guidance on isolated individuals, meaning those who withdraw from the majority of the regime, have limited contact with others, or spend most of the day in their cell, is contained in the Prison Safety Policy Framework. The guidance says that these prisoners are at heightened risk of harm and instructs Governors to have a system in place to identify and accurately record details of all isolated individuals, including the reasons given for isolating, methods of offered support, and the details of the regime being offered and taken. This information must be made available in the local Safety Intervention Meeting (SIM) to inform decisions about any subsequent supportive actions or interventions to mitigate the risk of continued isolation. Further guidance for staff is available on HMPPS intranet.

Key Events

23. On 22 May 2025, Mr James Bell was sentenced to 14 months in prison for actual bodily harm (ABH). He was sent to HMP Forest Bank. It was not his first time in prison.

24. A nurse completed Mr Bell's initial healthcare screen. The nurse recorded that Mr Bell had no thoughts of suicide or self-harm, no history of mental health issues and no issues with alcohol or drugs in the previous three months.

25. A prison custody officer carried out Mr Bell's first night interview and assessed that Mr Bell had no risk factors for suicide or self-harm.

26. The next day, a mental health nurse went to see Mr Bell for a well man screening (a routine assessment offered to prisoners). The mental health nurse recorded that she could not speak to Mr Bell because prisoners were in their cells and officers could not facilitate access. She was told to come back later when prisoners would be out on the landing. The mental health nurse spoke to Mr Bell through the door and told him how to apply to see the mental health team if he needed to.

27. On 26 May, a nurse saw Mr Bell for a second stage health screening. The nurse recorded that Mr Bell was chatty and engaged well and had no thoughts of suicide or self-harm.

28. On 28 June, Mr Bell handed a note to a night operational support officer (OSO). The note said that he wanted to be placed on the Do Not Unlock (DNU) list (a process at Forest Bank for recording prisoners that have asked for their cells not to be unlocked as they fear other prisoners) and wanted to be moved to a different wing because he was under threat. The OSO added Mr Bell to the DNU board in the staff office and recorded details in the wing observation book.

29. There is no record that staff spoke to Mr Bell to ask him why he thought he was under threat or why he had asked to be moved. There is no evidence that staff considered whether Mr Bell should be managed under the isolating prisoner policy instead of the DNU list. (The isolating prisoner policy at Forest Bank complies with the guidance in the Prison Safety Policy Framework and provides a process to manage prisoners who choose to engage with either none or only limited aspects of a normal prison regime.) Mr Bell was not unlocked with other prisoners in line with his request.

30. On 30 June, staff moved Mr Bell from C Wing to a single cell on A Wing (a standard residential wing). There is no record that C Wing staff gave a handover to A Wing staff to tell them that Mr Bell had been on the DNU list, nor did they record a handover in the wing observation book. The manager of A Wing said in interview that she thought Mr Bell had been moved as a standard move and was unaware he had been moved because he felt unsafe on C Wing. She said he was unlocked as normal initially but then a few days later, he started to be unlocked on a separate regime so that he only came out with one other prisoner. We were not provided with any evidence to explain why Mr Bell was unlocked on a separate regime on A Wing.

31. On 2 July, the prison received a phone call from the national intelligence unit telling them that Mr Bell had called them and said that he was going to be assaulted that

afternoon so for his safety, should be kept locked in his cell. The duty manager contacted the wing to tell staff about the call. Staff said that they already knew Mr Bell was under threat and staff were taking his meals to his door.

32. There is no record that officers went to speak to Mr Bell about the call nor did they add him to the DNU list, or consider whether he should be managed under the isolating prisoner policy. CCTV shows that staff took Mr Bell's meals to him and that he did not leave his cell again before his death.

Events of 6 July

33. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 6 July. She also obtained information from North West Ambulance Service. The following account has been taken from all sources.

34. At around 5.07am, an OSO completed the morning roll check. CCTV shows that he looked through the observation panel into Mr Bell's cell. In interview, the OSO said that he did not remember specifically looking into Mr Bell's cell so could not recall what he saw. He said the fact that he could not recall the check indicated that he had no concerns.

35. At around 6.40am, officers put the breakfast packs outside each cell. There was no requirement to check on prisoners.

36. CCTV footage shows that at around 8.21am, two officers started unlocking prisoners for work. When they got to Mr Bell's cell they tried to open the cell door, but the door felt heavy as if someone was leaning against it. One of the officers tried to look through the observation panel, but it had been covered so he could not see inside the cell. The officer forced the door open and found Mr Bell hanging from the door frame, with his wrists and ankles bound together with a bed sheet. The officer radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) but it did not go through on the radio, so he pressed his personal alarm. He cut the ligature from Mr Bell's neck and untied his wrists and ankles.

37. The officers moved Mr Bell onto the bed. They saw that Mr Bell was stiff, suggesting he had been dead for some time. They did not start CPR. A custodial operations manager (COM) quickly responded and radioed a code blue. An OSO in the control room called an ambulance.

38. Around two minutes later, healthcare staff arrived. They assessed that Mr Bell had rigor mortis (stiffening of the body that occurs two to six hours after death) and did not start CPR.

39. At around 8.39am, paramedics arrived and at 8.42am, they pronounced life extinct.

Contact with Mr Bell's family

40. At around 9.30am on 6 July, a prison manager appointed an officer as family liaison officer. The family liaison officer and the Director of Forest Bank went to the address recorded for Mr Bell's brother to break the news of his death. When they

got to the address, they found that no one was living there. The prison asked the police to assist in tracing a next of kin.

41. The next day, Mr Bell's sister called the prison and said that the police had been to her house and told her that Mr Bell had died. Mr Bell's sister gave the prison her address. The family liaison officer and the Director visited her to offer support.

Support for prisoners and staff

42. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

43. The Head of Safety told us that that officially postvention had not been rolled out throughout Sodexo, but elements of postvention were part of Forest Bank contingency plans, and all Listeners were trained in postvention.

44. After Mr Bell's death, a prison manager debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

45. The prison posted notices informing other prisoners of Mr Bell's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Bell's death.

Post-mortem report

46. The post-mortem report gave Mr Bell's cause of death as hanging. Toxicology found no evidence of illicit substances in Mr Bell's system. There was also no evidence of any third-party involvement.

Findings

Assessing Mr Bell's risk of suicide and self-harm

47. The Prison Safety Policy Framework requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under a process known as ACCT.

48. Mr Bell had no identified risk factors for suicide and self-harm. We are satisfied that staff appropriately assessed Mr Bell when he arrived at Forest Bank on 22 May, and that it was reasonable for them to conclude that he did not require the support of ACCT procedures at that time.

49. From 28 June, Mr Bell expressed fears for his safety and chose to leave his cell rarely (and not at all from 2 July). Staff never explored the reasons for this with Mr Bell. It is possible that had they done so, they might have identified a deterioration in Mr Bell's mental health, or an increase in his risk and could have put support in place. This is discussed further below.

Management of Mr Bell as an isolated individual

50. In line with the requirements of the Prison Safety Policy Framework, Forest Bank has a local policy on the management of isolated individuals contained in their safer custody policy. Forest Bank's guidance recognises that prisoners who isolate are more likely to self-harm and attempt suicide. The guidance states that if a prisoner is isolating then a Challenge Support and Intervention Plan (CSIP – the national case management model for managing those who are violent or pose a raised risk of harming others through violent behaviours which can also be used to support victims) referral must be completed and an email must be sent to the safer custody team to inform them. The prisoner must also be referred to the mental health team. The policy says that prisoners who have been identified as isolating should be monitored through wing staff and key workers.

51. On 28 June, when Mr Bell told the OSO that he was under threat and did not want to come out of his cell, the OSO put Mr Bell's name on the DNU list and recorded it in the observation book. Wing staff should have spoken to Mr Bell the next day to find out the reasons for his request. Staff should have considered whether Mr Bell was isolating and if he was, they should have followed the steps listed in the isolation policy including putting a support plan in place.

52. There is no record that C Wing staff gave a handover to A Wing staff to tell them that Mr Bell was on the DNU list, nor did they record a handover in the wing observation book. There was also no record that staff spoke to Mr Bell about the call from the national intelligence unit, though they were already aware that Mr Bell was under threat. CCTV shows that from 2 July, Mr Bell did not leave his cell at all and yet he was still not considered an isolating individual.

53. At interview the investigator asked the Head of Safety at Forest Bank about the process staff should follow if a prisoner asked to be placed on the DNU list. The Head of Safety said that there was no specific process for prisoners asking to be

placed on the DNU list but she would expect staff to establish the reasons why the prisoner felt unsafe and if they were isolating, to follow the isolation policy.

54. If staff had treated Mr Bell as an isolating prisoner, they would have been required to open a CSIP and a plan would have been put in place to support him. In addition, prisoners supported by CSIP are discussed at the Safety Intervention Meeting (SIM) and would be allocated a key worker (currently Forest Bank is allocating key workers to priority groups only). Despite asking to be placed on the DNU list because he felt unsafe, staff did not consider that Mr Bell was isolating and provided no support. Whichever process Mr Bell should have been managed under, we consider that staff at Forest Bank showed a collective failure of professional curiosity. However, more broadly, we consider that the existence of two separate policies to manage prisoners displaying very similar behaviours but which place quite different responsibilities on staff is unhelpful at best. We recommend:

The Director should:

- **Review the appropriateness of maintaining both a Do Not Unlock process and an isolating prisoner policy to manage prisoners who do not engage with the standard regime.**
- **Ensure that staff are clear of their responsibilities under either approach including establishing the prisoner's reasons for not engaging with a standard regime, and recording and communicating the prisoner's status, particularly if the prisoner is moved.**

Clinical care

55. The clinical reviewer found that the clinical care Mr Bell received was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.

Inquest

56. At the inquest, held from 22 to 26 June 2026, the jury concluded that Mr Bell died by suicide.

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